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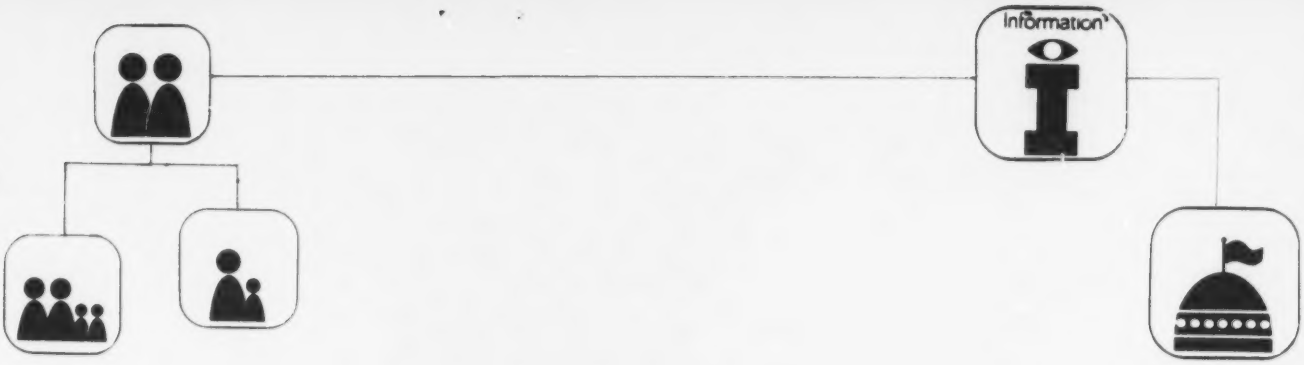
ABSTRACT

This report contains highlights from a seminar on integrated approaches to youths' health problems. Comments by these panelists are summarized: Renee Jenkins, Director of Adolescent Medicine, Howard University Hospital, and President of the Society for Adolescent Medicine; Vivian L. Smith, Deputy Director, Office for Substance Abuse Prevention (OSAP); Judith Katz-Leavy, Assistant Chief, Child and Family Support Branch of the National Institute of Mental Health; and Marilyn Lanphier, Director, Adolescent Section, of the Oklahoma State Maternal and Child Health (MCH) Service. These topics, discussed at the seminar, are summarized: (1) reasons why integrated approaches to adolescent health problems are gaining more support; (2) the assumptions that underlie OSAP's at-risk youth demonstration programs; (3) characteristics of a good comprehensive substance abuse intervention program; (4) reasons why the Child and Adolescent Service System Program, which focuses on helping states coordinate and strengthen services for severely emotionally disturbed adolescents, is needed; and (5) the integrated adolescent services provided by Oklahoma and Colorado. A background briefing report is also included which contains information about integration of services for youth, programs promoting integrated services for adolescents, state maternal and child health adolescent activities, and parents as resources. (28 references) (LLL)



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Integrated Approaches to Youths' Health Problems: Federal, State and Community Roles

July 7, 1989, Mansfield Room (S.207), the U.S. Capitol

Panelists: **Renee Jenkins, M.D.,** Director of Adolescent Medicine, Howard University Hospital and President of the Society for Adolescent Medicine
Vivian L. Smith, M.S.W., clinical social worker, Deputy Director, Office for Substance Abuse Prevention, ADAMHA/HHS
Judith Katz-Leavy, M.Ed. Assistant Chief, Child and Family Support Branch, NIMH/HHS.
Marilyn Lanphier, R.N., M.P.H., Director, Adolescent Section, Maternal and Child Health Service, Oklahoma.

Moderator: **Theodora Ooms,** Director, Family Impact Seminar

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BACKGROUND BRIEFING REPORT.....pages 1 to 22

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Integrated Approaches to Youths' Health Problems: Federal, State and Community Roles

Background Briefing Report
and
Meeting Highlights

By

Theodora Ooms and Lisa Herendeen

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1100 Seventeenth Street, N.W., The Tenth Floor, Washington, D.C. 20036, 202/467-5114

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Integrated Approaches to Youths' Health Problems: Federal, State and Community Roles

Highlights of the seminar meeting held on July 7, 1989, Mansfield Room (S.207), the U.S. Capitol (a supplement to the Background Briefing Report)

There is growing acknowledgement of the fundamental mismatch between adolescents' health needs and the present system of fragmented, categorical health services that are available to teenagers. This situation has particularly serious implications for the large group of teenagers who are engaged in multiple high-risk behaviors and for those with serious chronic illness or handicap.

This seminar was intended to examine new integrated approaches for delivering health care to adolescents that are being tried at federal and state level. Efforts to integrate services---that is to coordinate and link a range of services to meet the related health needs of adolescents in a holistic way---are being carried out under the auspices of three main sectors of the Public Health Service. Panelists representing these three sectors---substance abuse, primary health and mental health---each described recent efforts at integration and identified some of the key elements that these programs shared.

Renee Jenkins, Director of Adolescent Medicine, Howard University Hospital and President of the Society for Adolescent Medicine, discussed the reasons why integrated approaches to adolescent health problems are gaining more support, the obstacles to integration and her personal experience in setting up comprehensive youth programs in Washington, D.C.

She stated that there is both theoretical and clinical support for adopting an integrated approach to adolescent health care. First, many of young people's deviant behaviors appear to be linked and to have some common antecedents. The three major causes of fatality among teens (accidents, suicide and homicide) and the five major causes of adolescent morbidity (sexually transmitted disease, unintended pregnancy, mental health problems/depression and non-fatal accidents) are often the result of a cluster of risk-taking behaviors. Jessor et al. were the first to set forth a theoretical model for uniting these problem behaviors. Irwin and Millstein have added to this model the importance of biological and psychological maturation factors. While these models demonstrate that teen health problems are interrelated, they do not help explain why some teenagers who engage in risk-taking behavior are successful in avoiding serious problems.

Second, there is strong clinical support for integrated programming. For example, clinicians find that there is a link between the use of cigarettes and involvement with drugs and sex. In some cases teenagers are bartering sex for drugs. This clinical experience has led many to advocate that categorical services should be brought together and adolescents' health needs be viewed in a more holistic fashion.

Dr. Jenkins also noted that integration is most effective when it is provided at the preventative, primary or secondary level of care. In her view, at the tertiary level, when kids are in serious trouble, categorical, specialized services, are more useful, at least initially.

Building on the findings of a recent report of the Grant Commission on Youth, Work and Citizenship, she outlined seven obstacles to integrated care.

- Funds are targeted on deviant behaviors rather than health promotion.
- The media gives publicity to "front page" problems, i.e. gang wars, so programs are set up around these issues.
- Comprehensive services are sometimes called "the invisible youth service." It is hard to sell comprehensive care because there is less understanding about this approach among the general public.
- There are also turf battles, everyone involved in an area wants their own programs. When youth services are combined there is always an issue of control.
- Comprehensive programs with multiple goals are difficult to evaluate and therefore hard to fund. There are fewer funders for comprehensive programs than for specific problems areas like drug abuse.
- Program administrators need to constantly reinforce a comprehensive philosophy with staff who tend to be problem focused.

In conclusion, Jenkins said that she is encouraged by the new trend toward promoting health for the population in general and she added that this is a good way to put integrated services for adolescents on the front burner.

Vivian L. Smith, Deputy Director, Office for Substance Abuse Prevention, (OSAP) ADAMHA/HHS described the Office which was created two and a half years ago with the passage of the Anti-Drug Abuse Act, 1986. She emphasized that OSAP has primary responsibility within the federal government for community based and other drug abuse prevention and intervention programs (see p. 8-12 of this report). OSAP supports programs for high-risk youth and families through demonstration grants, communication programs, and technical assistance to organizations and communities. The legislation establishing OSAP defines high-risk youth very broadly (see p. 9).

Smith outlined several **assumptions** that underlie OSAP's at -risk youth demonstration programs.

- An outside agency cannot come in and solve a community's drug problems; rather, it can provide technical assistance, financial support, and other types of services to augment the concern, commitment, and personal resources drawn from the community.
- Programs should intervene very early in the life cycle, before alcohol and drug use begin.
- Programs should have a comprehensive approach that includes the entire spectrum of services: prevention, intervention, treatment, rehabilitation and aftercare.
- Programs should encourage communities to take a more comprehensive approach to their drug problems, since drug use is not an isolated phenomena.

She described several successful OSAP demonstration programs that exemplify these principles: A project working with African American Head Start children in Atlanta, Georgia; Wilmington, Delaware's Cluster Against Substance Abuse; the Boys Club, New York City; and the Gateway Program operated by the YMCA in Richmond, California, a San Francisco suburb.

Smith outlined the **characteristics** of a good comprehensive substance abuse intervention program as follows:

- First, a successful program will be comprehensive in order that previously isolated services are centralized, and the availability and accessibility of services will be increased. Service providing agencies can form a consortium to further enhance cooperation and a holistic approach. In urban areas, neighborhood consortiums can link individual communities with the city's major service providers.

- The program recognizes that communities are not stagnant; rather, they are continuously changing. It has a long-term prevention approach that adapts to the changing dynamics of the community.

- A comprehensive, community-based prevention program should target not only the individual, but also the community itself. It modifies the social, economic, and cultural conditions within the community that facilitate and/or condone drug use.

- It spreads out the responsibility for solving a community's drug problem among many agencies.

- One service system is identified that will have *primary* responsibility for prevention.

- The program has input from the target population, youth and their parents.

She said that OSAP is also attempting to learn how some communities have successfully overcome the institutional barriers to integrated programming. They will then take that knowledge and develop a framework or prototype for programs throughout the nation to follow.

Finally, Smith concluded with some **lessons** OSAP has learned from working in communities with high-risk youth.

- Meet with young people in familiar settings.

- Get the entire family involved, and promote teenagers' bonding to family, school, and peers.

- Youth's basic needs for food, clothing, shelter, and health care must be met.

- Positive motivators, such as a job training or recreational activities, work more effectively than coercion. Parents, too, respond to prizes such as ball-game tickets and dinners or cash awards for completing programs.

Judith Katz-Leavy, Assistant Chief, Child and Family Support Branch, NIMH/HHS, talked about the Child and Adolescent Service System Program (CASSP)which is administered by NIMH and focuses on helping states coordinate and strengthen services for severely emotionally disturbed adolescents. The basic structure and philosophy of this program is well described, she said, in the briefing report on pages 10-13. The CASSP systems of care model can be applied to many other adolescent health areas and is illustrated in the charts on pages 21 and 22.

Katz-Leavy outlined reasons why this program was needed. Before this federal project began in 1984, very limited children's mental health services such as outpatient treatment and some inpatient treatment or emergency services were available in most communities. However, day treatment,

home-based services, prevention, foster care, and group therapy were basically unavailable or had limited access and/or were in very short supply. The CASSP programs have tried to identify ways to establish a range of services for adolescents. "We tried to promote a concept of community-based, child-centered, family-focused care," said Katz-Leavy.

One of CASSP's strong themes is the need to empower parents through involving them as resources in policy development, program planning and in the delivery of services to their own children. With the help of the CASSP funded Research and Training Center at Portland State University, CASSP has developed a model of parent/professional collaboration. In 1988 it was able to expand these parent/professional teams in all regions of the country, known as **Families as Allies.** These teams are available to states if they want to use them.

There are a number of states that have used CASSP monies very constructively. Ohio and Georgia developed a model of state and local interagency coordinating committees to do collaborative treatment planning for children with multiple problems (see p. 12). This model has been replicated in Hawaii, Louisiana and Vermont. Washington state and West Virginia are now adopting the model first developed in Alaska, the Youth Initiative, which established individualized treatment planning for children with serious emotional disturbances by using wrap-around services and combining funding streams (see p. 12).

Virginia is an especially good example of state interagency collaboration stimulated by CASSP monies. Five departments in the state government made a joint budget request for services for seriously emotionally disturbed children and youth. These agencies included : corrections, education, health, mental health and substance abuse. The joint request was supported by an eleven member coalition of organizations dedicated to improving services for handicapped children and adults. As a result, mental health services in Virginia have received a 50% increase in biennium funds amounting to a total of $24.1 million in new funds. Of this total, $4.8 million will be spent on new innovative programs for children and adolescents with serious emotional disturbances, with $2.6 million allocated to interagency collaborative programs.

Katz-Leavy concluded by saying that the CASPP program is at a crossroads. Many states have adopted the CASPP model. She said that the challenge now is to get local providers to implement these models and ideas in their communities at the service delivery level. In the next five years the CASPP program will attempt to work with the private sector and professional organizations. They will also be looking at the third party payor system. They fear that many youth are being unnecessarily hospitalized because it is all private insurance will pay for.

Marilyn Lanphier, Director, Adolescent Section, of the Oklahoma State Maternal and Child Health (MCH) Service, discussed Oklahoma's and Colorado's MCH adolescent services as examples of successful integrated health programs.

She stated that the groundwork for **Colorado's** activities was laid in the early 1980s when an ad hoc health committee produced "Adolescent Health in Colorado," a first of its kind report which examined a wide-range of adolescent health problems in the state and the nation. The report provided trend data, discussed nine major adolescent health problem areas, brought disparate officials together, and generally stimulated interest in adolescent health program development. The report also recommended that there should be cooperation between the community and schools in matters of adolescent health, an idea which resulted in the award of a SPRANS (Special Projects of Regional and National Significance) grant. SPRANS is a federal block grant set-aside program administered by MCH.

The grant funded the **Colorado Adolescent Health Project** from 1983-87. Funds focused on training adolescent health care professionals to go into schools to reach youth (see pages 13 & 14). Another component of the project was parent involvement. Parents are trained to help their

adolescents with decision making, self-responsibility, and communication skills. A second SPRANS funded project, **Partners in Teen Health,** began in 1987. This project is developing a model for a community development planning process, involving all major sectors of the community in efforts to improve adolescent health.

Lanphier then described some of the adolescent activities being conducted in her state of **Oklahoma.** Oklahoma State Department of Health has participated in a Robert Wood Johnson funded "high risk" adolescent project. The project enabled Oklahoma to set up 12 rural adolescent health clinics in county health departments. MCH, through block grant funds, provided the staffing, equipment and supplies, and the Robert Wood Johnson grant provided in-service training in adolescent health care to professionals such as social workers and nutritionists who were providing care in the clinics .

The Oklahoma state department of MCH believes that communities are key to developing services for teens. But placing the health projects in some communities was difficult, said Lanphier, because communities were used to focusing on one type of health problem rather than on the whole adolescent. Schools also were initially reluctant about working with the health care professionals, she said. For example, in one case the schools thought that it was an invasion of privacy to ask students "did you drop out of school because of pregnancy?" But now many communities are requesting services that impact on the whole adolescent rather than fragmented services that only deal with one or two the the adolescent's needs.

Lanphier concluded by saying that today's health professionals, school personnel and community leaders across Oklahoma are focusing on a wide range of adolescent problems, not just teen pregnancy. Programs, she believes, are thinking more integratively, are incorporating families and working on prevention. Interestingly, community leaders that work with youth said that they appreciated an integrated approach because it decreased the amount of time they spent serving on a variety of committees that focussed on specific problems.

As an example of how the integrated approach is gaining recognition, Lanphier said, was seen at the Governor's Summit on Families, Children and Youth. Their agency, along with a range of other health and education agencies, were able to provide participants with information on the major health problems of adolescents. The Adolescent Health Task Force, that these groups formed, made recommendations that were included in the summit's report. Lanphier also said their agency is excited about an upcoming state-wide conference called **Hope for Our Youth: Local Communities Can Make It Happen**, where they will present adolescent needs assessment and data for each individual county and highlight programs across the state for adolescents.

Points made during discussion

- "What is the Federal role in promoting integrated planning besides providing money?" asked a congressional staffer.

  Vivian Smith answered that federal funds also go toward monitoring prevention programs and information dissemination which helps the field of prevention overall.

  Theodora Ooms pointed out that the legislation that set up OSAP was not categorical and not tied to particular narrow types of problems and thus allows for flexibility to states to use the money for integrated programs. She added that block grants and waiver authority are other ways the Federal government can encourage flexibility. Thus, it is the way legislation and regulations are written and carried out that can promote integration. It is not just the amount of dollars.

Judith Katz-Leavy said that in recognition of the broad range of needs of emotionally disturbed children and youth, in 1987, NIMH established the Child and Family Support Branch and, at the same time, expanded the mandate of CASSP to include high-risk youth. She also added that there is some tension and controversy over what the ADAMHA role should be in relation to training and providing services.

In response, Vivian Smith said that OSAP, one of ADAMHA's agencies, is definitely concentrating on services and working directly with local organizations to provide them.

Lanphier, speaking from a state perspective, said that the federal government needs to listen to us, just as we listen to the concerns and knowledge of local groups within a community. She said also that one problem with federal funding is that it sometimes lumps adolescents with children and fails to recognize adolescents' unique problems.

- "If the Federal government were to spend marginal new funds on adolescents to try to get better health outcomes, would you prefer to see it as expanding fundamental access through Medicaid or in categorical program dollars?" one participant asked.

Jenkins answered that she would prefer categorical money targeted on youth because it can reach young people that are not eligible for Medicaid and do not have health insurance. She said this is especially needed for young workers with no insurance. She said that there is discussion now of making Medicaid available based on medical need rather than income.

Katz said that in many states Medicaid does not even cover community-based mental health services, so that expanding Medicaid money would not help adolescents obtain the treatment they need. She added that Medicaid tends to cover only specific health problems and is not a good way to fund more integration.

- "What is the best way to get schools interested in integrated programs?" asked one participant.

Lanphier said getting schools interested begins with establishing elements of trust with mid-level people who can then influence superintendents to get involved in a program. "We provide data to schools and try to listen to them. We must understand that they are overwhelmed and health is only one of their missions," said Lanphier.

Vivian Smith pointed out that one of their programs, PADRE, worked with teens a full year before approaching schools and said "look at what we've done with these teenagers. Now lets work together." They established trust through the teens.

* **Additional Resources:** Two new efforts to integrate/coordinate statewide, school-based health education and prevention efforts have been brought to our attention. These are:

FLORIDA. The Florida Department of Education has established a Prevention Center which aims to provide coordinated leadership to the currently fragmented programs addressing drug free schools, AIDS prevention, youth traffic safety, pregnancy and suicide prevention. The Center operates a clearinghouse, publishes a newsletter, encourages school/community/business partnerships and conducts special projects.

Prevention Center, Department of Education, Knott Building (106 Winchester Ave.) Tallahassee, FL 32399. 904-488-6304. Contact: John L. Winn, Program Director.

WISCONSIN. The Department of Public Instruction has begun a five-year initiative, called the Prevention Connection, to provide schools with a philosophy, framework and training materials to help them coordinate their various prevention and education programs.

Prevention Connection, Department of Public Instruction, 125 South Webster St., Madison, WI 53702. 608-266-3390. Contact: Raejean Kanter, Consultant, Human Growth and Development.

INTEGRATED APPROACHES TO YOUTHS' HEALTH PROBLEMS: FEDERAL, STATE AND COMMUNITY ROLES

Background Briefing Report

INTEGRATION OF SERVICES FOR YOUTH: A NEW APPROACH

There is a growing consensus that the present health care system is too fragmented and compartmentalized to respond effectively to the major health problems of adolescents today. High rates of adolescent mortality, pregnancy, sexually transmitted disease, substance abuse, and depression are now understood to have complex, interrelated causes and consequences. Thus, categorical programs that target only one type of problem behavior, and seek simple solutions are quite inadequate. But, short of a complete overhaul of our patchwork systems of care, what can be done?

Over the past few years, a new approach providing more comprehensive and coordinated, prevention and treatment services for adolescents, within the present framework of medical care, has been tried in a number of demonstration programs. These types of programs are clearly gaining broad professional and public support, and preliminary evaluations are promising. Such comprehensive models of adolescent services are being sponsored, quite independently, under the auspices of the three major "umbrella" systems of health care: substance abuse, mental health and maternal and child health.

Service integration is a major policy and program strategy shared by these demonstrations in an effort to remedy the gaps and fragmentation in services for young people. Services are integrated within the umbrella health system and across them. They also reach beyond health systems to include linkages with education, juvenile justice, child welfare, social services, and employment and training service systems.

Health service integration is clearly a desirable goal for all age groups and income levels. However, it assumes a special urgency for adolescents designated "at risk," namely, those who engage in multiple risk-taking behaviors, who come from poverty backgrounds and/ or whose families have multiple problems and provide their teenagers with little support and guidance. The AIDS epidemic provides additional impetus for more integrated approaches to prevention and treatment: adolescents are vulnerable to HIV because many experiment with unprotected sex, sometimes with HIV drug users.

Integration is a strategy designed to respond to three major problems within the existing systems of health care: the **gaps**---when needed, available services simply don't exist and those that exist are inappropriate; the **fragmentation**---when several services are needed, are available, and yet are quite uncoordinated; and **lack of access**---when the patient is not able to pay for services. The important issue of financial access, which was touched upon in the first seminar, will not be discussed in any detail in this report. We focus here on organizational issues involved in integration: how services for adolescents are planned and administered. We find that while many of the tools and strategies used to achieve integration are familiar, the conceptual framework underlying these emerging models of adolescent health care is quite new and far reaching.

This report summarizes the new approaches being sponsored by three relatively new, federal programs located in three federal agencies within the Public Health Service: the Child and Adolescent Service System Program in the National Institute of Mental Health (NIMH), the Office for Substance Abuse Prevention in the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), and statewide activities sponsored by the Bureau of Maternal and Child Health, within the Health Resources and Services Administration (HRSA).

Integration strategies to address a variety of youth's health problems are also being substantially sponsored by the private sector. The Robert Wood Johnson Foundation has funded four major demonstration programs targeting high-risk youth with various health problems. They are briefly described in this report. We discuss the role of parents as a resource in integrated approaches and the growth of the parent movement.

However, we begin the report with a discussion of several preliminary questions:

- What does integration of health services mean from the perspective of the young person, his or her family, the health care professional and the program provider? Why is integration important to them?

- What are the essential concepts and principles of effective integration? What are the major barriers to integration and the key tools and strategies that are being used at federal, state and community levels to achieve it?

Note: For a review of trends in adolescent health and a discussion of their health care problems and needs the reader is referred to the background briefing report for the first seminar in the series on adolescent health, *The Unique Health Needs of Adolescents: Implications for Health Care Insurance and Financing*.

Rationale for Integration

(Sources: Brooks-Gunn et al., 1988; Donovan and Jessor, 1985; Dryfoos, 1989; Hein, 1988; IOM, 1982; Hobbs and Perrin, 1985; Jessor and Jessor, 1977; Klerman, 1986; Knitzer, 1982 & 1987; Schorr, 1980 & 1988)

There is a strong theoretical and research rationale for a holistic approach to the promotion of adolescent health and the prevention and treatment of health problems, as discussed in some detail in the first seminar briefing report. In addition, studies of service systems for children and adolescents have highlighted the fundamental mismatch between their needs and the services provided. The main points of this literature can be summarized briefly as follows.

- The major public concern about adolescents' health is with the negative consequences of their risk-taking behavior. A teenager who is substantially involved in one type of problem behavior is also highly likely to be engaged in others.

- Adolescents' serious risk-taking behavior is determined by a complex interaction of biological, psychological and environmental influences. The behavior may result in their death or frequently has damaging consequences on their physical and emotional health, school performance, employability, and family and social relationships.

- Adolescents with serious chronic, physical or emotional illness and disability need a wide range of medical, educational, rehabilitative and psychological services which are frequently not available.

- The major focus of adolescent health services until quite recently has been on sexuality related services for teenage women. The AIDS epidemic provides additional reason for broadening the focus to include services to young men, (education and promoting condom use) and to coordinate such services with programs focusing on substance abuse. Adolescents, by engaging in many high-risk behaviors, constitute a "bridging" group to those already infected and are especially at risk of heterosexual transmission. In addition, HIV infected pregnant teens, although small in number, have a 50% chance of passing on the infection to their infants.

- Adolescents' health problems of all kinds deeply involve their parents and other family members who may be a part of the problems, are always much affected by them and, generally, are a major resource in any solution.

- Traditional methods of public health prevention and medical diagnoses and treatment which focus narrowly on biologically oriented solutions for individual's medical problems are ineffective when applied to adolescents' bio-psycho-social problems occurring in the context of their family and social environment.

- There are a wide variety of service systems designed to help teenagers, yet which system a particular teenager will end up with is often quite arbitrary and more a function of social class and the availability of funds than need. For example, violent behavior will be labelled as delinquent in a low-income, minority, inner city, youngster who may end up, via the courts, in a remand home for six months. This same behavior in a middle class, white, suburban youngster will be diagnosed as a psychiatric "adjustment disorder" and the teen may then spend several weeks in a private psychiatric hospital.

- In order to become eligible for most categorical services, a teenager must be given a label, or medical/psychiatric diagnosis. Ironically, when a teenager is seen to have several types of problems, and is given a dual-diagnosis or primary and secondary diagnosis or label, it is usually much more difficult, not easier, to obtain the services he or she needs. For example, a runaway shelter will not accept teenagers who have drinking problems, a maternity home will not accept pregnant teens who are "disturbed," a psychiatric clinic will not treat a youngster who is also retarded or deaf.

- There are many gaps, biases and distortions in the type of services available to meet adolescents needs in primary health, mental health and substance abuse. In all three areas the services that are most readily available are the most extreme and the most expensive: namely inpatient, hospital care. Preventive and out-patient services, services based in the home and community, and partial/day hospital services either do not exist or are in short supply.

Consumer perspectives on the present system. From the teenage patients' and their families' consumer perspective there are a number of logistical problems with the organization of the present largely categorical system, quite aside from the basic issue of availability and financing. Typically, each service is offered at a different time, place, with different providers, eligibility rules, forms to fill out and requirements to meet. When several services are needed it takes a great deal of level-headed planning and organizational ability to use all these separate services regularly and appropriately.

For example, the basic medical services a young teen mother and her baby will need includes: pre-natal and post-natal care, family planning, baby immunizations and well care, and may include extra nutritional and developmental screening services (from the WIC and EPSDT programs). In addition, the young mother may be referred for parenting education classes, support groups, and

counselling sessions. If, in addition, she has any further special health related problems or needs such as a venereal disease, or drug abuse, her contacts with medical services multiply.

In order to obtain public income support she will have to make repeated contacts with local welfare officials. Further, she is usually now expected to complete her education, seek job training or employment which also means finding suitable child care. Overall, she may have contact with a dozen or more health and social service personnel at any one time, personnel who typically turnover rapidly.

It is perhaps not surprising that many teenage patients fall through the cracks in these systems and do not get the services they need or follow through with the treatment recommended. This complex, convoluted pattern imposed on those adolescents seeking health care is even more frustrating for a family attempting to coordinate the multiple health, education and social services needed for their severely disturbed, or multiply handicapped teenager.

Health Care Professionals Perspective

Such fragmentation has many negative results on efficiency and effectiveness of the services provided in addition to the stress, frustrations and burden on the consumer and provider. On the one hand there is much duplication of information, examinations and testing procedures. On the other hand, because each service and professional is so specialized, serious problems are missed. No one is assigned responsibility for assessing the health and well-being of the whole adolescent, or for seeking the connections between problems. For example, the ob/gyn nurse examining a pregnant teenager or teen mother does not routinely conduct a urine test for drug use and will typically fail to enquire about her patterns of drinking or drug abuse.

Further, it is rare for the various health care providers at these different clinics and agencies to communicate with each other informally or share written records. Without such active collaboration, misdiagnoses occur and advice and treatment regimens may work at cross purposes. When referrals are made, there is seldom a system in place to follow up the contact.

Most primary health care professionals do not directly assess the family context of the adolescent to determine the extent to which the family environment contributes to the problem and/or whether there is anyone in the family, including the extended family, who needs to be mobilized to help. (Happily, substance abuse professionals, and to some extent mental health professionals, are somewhat more likely to work collaboratively with adolescents' parents.) This can be bewildering to a concerned, frightened or angry parent who frequently feels shut out or blamed by the health care professional. When there is no communication with the parents, or surrogate parents, the clinic nurse or program professional may be giving instruction and advice to the teenager that is contradictory to that she receives daily at home from others.

Alternatively, this failure to work collaboratively with the parent may simply reinforce the parent's own denial of the problem and their lack of willingness to assume responsibility or be involved. In addition, the families' own needs for either concrete, practical services and education, support and treatment services are ignored even though they may be essential for the effective treatment of the adolescent. This failure to involve the family is in part a result of lack of training, skills and time but in a more fundamental way reflects the narrow view of most professionals' understanding of adolescent health problems. It also reflects health care professionals' actual and perceived constraints imposed on their contacts with adolescents' parents by their firm commitment to patient confidentiality. (Parent involvement and adolescent patient confidentiality will be a topic of a future seminar.)

Administrators' perspective. A health care program administrator who strives to provide a range of comprehensive diagnostic and treatment services to adolescents is forced to seek funding

from a variety of categorical public and private funding sources---both direct federal and state grants and reimbursement programs. While this patchwork funding does assure a modicum of stability (as compared with reliance on a single funding source) it creates enormous practical and logistical problems. Each source funds on a different timetable, requires different proposal submissions, methods of reporting, separate audits and so forth.

Moreover, most funds are only provided for direct medical services or specified allowable administrative costs. It is very hard to fund counselling, educational, outreach and consultation activities with other professionals and agencies, the expenses of task force or case conference meetings, and planning activities---all of them crucial elements of successful integrated, adolescent health care.

Public health officials' perspective. The patchwork of categorical health care service programs that has been built up since the 1960s is now paralleled by a profusion of new categorical **prevention** programs targeted on youth and based in communities or, frequently, in schools. For example, in Colorado, there are currently at least seven different statewide prevention efforts focussed on adolescents. And high schools across the country typically provide a half dozen or so educational preventive programs such as safe driving and drug free schools programs, suicide prevention hot lines, pregnancy prevention, AIDS prevention, and sexual abuse awareness programs all at the same time, administered independently of one another.

This plethora of prevention efforts targeting the same youth population, may deplete schools' and communities' scarce professional and volunteer resources and energy and creates confusion for the intended audience.

There are many barriers that need to be overcome before existing service systems can work together in an integrated fashion. Deeply ingrained attitudes and habits, natural tendencies to protect bureaucratic and professional turfs and special interests help to maintain the present system of fragmented care. Moreover, politically, it is far easier to gain public support for programs that promise categorical solutions to specific, highly visible problems. Nevertheless, the lessons of recent years suggest that movement in the direction of more integrated care is possible, if slow, and that there are a number of tools available to promote integration.

Definition of Integration.
(Sources: IOM, 1982; Klerman, 1986; Stroul and Friedman, 1986 & 1988)

Although services **integration** is an idea that commands considerable support it clearly means different things to different people. As discussed in the report of a national study of health services integration, sometimes the term is used interchangeably with **coordination** and **linkage** (Institute of Medicine, 1982).

However, although coordination between existing elements of service is an important component of an integrated approach, it seems clear that for most people integration means considerably more than this. Loosely, it comes to mean any approach that "makes health services work more effectively for the consumer," solving the problems we have identified above. This usually includes providing a continuum of treatment services ranging in intensity from education/prevention, to inpatient care. It also means linking services across different health domains (health/mental health etc). Finally, integration means that patients are able to move smoothly from one part of the system to another.

In the adolescent field, current comprehensive models of prevention and treatment move beyond these somewhat mechanical, if essential, reforms to construct a new framework based upon a

rethinking of the relationship of health to other systems. These basic concepts and principles have been most clearly articulated in several publications describing the new federal program for severely disturbed children and adolescents---the Child and Adolescent Service System Program---but they are implicit in many of the program activities sponsored by primary health care agencies and substance abuse agencies. These central assumptions and principles of integrated services for adolescents are as follows.

- The adolescent is viewed as a whole person with bio-psycho-social needs that are interdependent.

- Services must be designed to meet the needs of the adolescent and family, rather than the teenager and family having to accommodate to the rules and limitations of particular programs.

- Appropriate health care for adolescents needs to be delivered by a variety of professional disciplines working together to address adolescent health needs in a holistic way. These needs may often best be provided by non-health care agencies, e.g. education, social services, employment and training. The adolescent is viewed within the context of family and community. A context-driven approach values and respects diversity of racial, ethnic and cultural background and physical setting and strives to deliver services that are sensitive to these different contexts.

- The family is considered an important focus of providing care to the individual, and needs to be involved, whenever feasible, as a partner in planning the services and in their delivery. The community, especially the informal leaders, needs to be involved in assessing adolescent health needs and problems and planning any new prevention or treatment programs.

How is integration achieved?

Case studies of well integrated, comprehensive adolescent programs document that there is no blue print for success. Each state, and local community requires a unique blend of mechanisms, strategies and approaches tailored to its particular needs and resources. However, a number of organizational tools have proved useful to many service integration efforts for adolescents. They are listed below, grouped according to the different levels of service implementation.

Patient level

---**Screening instruments** designed as a guide to the health professional's examination or interview with an adolescent patient such as the Home, Education, Activities, Drugs, Sex and Suicide/depression checklist (HEADDS) developed and tested in a Los Angeles program. This and other kinds of brief checklists help identify other possible problem areas that may need further in-depth assessment. Some of these instruments are paper and pencil forms filled out by the adolescent and family.

---**Case managers** are professionals assigned to be responsible for identifying the range of services the adolescent needs and ways to pay for them; assure that referrals are successfully completed, coordinate the variety of services, and keep the flow of communication ongoing between various service providers and the patient and family. These case managers are an extremely important resource to adolescents with multiple needs, and to the severely emotionally disturbed, chronically ill or handicapped who require many different types of services.

---**Case conferences** in which all the different professionals involved in the care of an adolescent or family meet together to plan and review progress are a critical tool when the teen and family are involved with seeking services from several different agencies.

Agency and Community Level

---**Co-location of services** together under one roof (one-stop services shopping) in a place easily accessible to teenagers has been a central concept of many of the innovative models of comprehensive health care, including the school-based clinics. Neighborhood and community health centers fulfil this purpose also, and some have specialty clinics for adolescents, yet the range of the services they provide are rarely as extensive as the demonstration projects. Physical co-location does not guarantee improved communication and collaboration, but it certainly facilitates it.

---**Sharing of office staff**, space, equipment and financial resources between different divisions, programs or agencies.

---**In service staff training and development** focused on adolescents' needs across agencies, divisions, professional specialties and disciplines.

---**Interagency committees** for assessing needs and planning improvements in services.

---**Interagency agreements** to establish referral and follow up linkages.

---**Community task forces** involving both formal and informal leaders, and representatives of parent groups established to assess needs and plan and implement service improvement.

---**Community or school-based surveys** to provide quantitative data regarding the prevalence and incidence of teen health problems and assessment of service needs.

---**Community or statewide professional or public meetings**, conferences or hearings to improve awareness and knowledge of adolescent health needs and problems.

State Level Integration Strategies and Tools

---**Statewide data collection efforts** and/or compilation and correlation of existing data to identify adolescent health trends and geographical areas of high risk for targeting integrated services.

---**Legislative mandates** to consolidate service delivery efforts or establish new comprehensive service programs.

---**Commingling of federal categorical funds**.

---**Negotiating waivers** from federal categorical regulations to obtain more flexibility.

---**Administrative reorganization** to bring a number of adolescent and child services under one administrative umbrella, and or to designate one person or office to assume the leadership for planning and coordinating such services.

---**Pooling resources of state agency staff**, physical space and funding from different divisions or agencies to support funding of innovative activities.

---**Identifying flexible dollars** that can be used for coordination, planning and other generally non-funded activities.

---**Mobilizing private sector resources** to match public efforts.

Federal Level

Ever since the sixties, the federal government has tried a variety of mechanisms to achieve more integrated and coordinated service delivery. The IOM report (1982) provides a summary of these efforts. Block grants, for example, are, in part, a strategy designed to provide states with the flexibility to achieve more coordinated services. However, the political pressures for more visible program accountability for federal dollars create a strong trend to re-categorize block grant funding. Additional strategies that have played a role recently in federal efforts to promote more integrated services for adolescents are noted below.

---**Interagency transfer of funds**, for example, the MCH/ OSAP Pregnant Drug Abusers project.

---**Agencies and Departments joint funding** of projects for example, the Youth 2000 projects funded by Departments of Labor and HHS and the teen parent demonstration grants funded by the Family Support Administration and Office of the Assistant Secretary for Planning and Evaluation within HHS.

---**Interagency task forces,** such as the OSAP interagency advisory group and the HHS Secretary's Panel on Teen Pregnancy Prevention.

---**Legislation providing flexible**, non-categorical dollars to be used as "glue" money and support integration activities at state level, for example, the CASSP program.

---**Legislation that funds activities** for broad populations at risk rather than narrow categories of specific illness or behavior, such as the OSAP high-risk youth program.

---**Dissemination and diffusion of knowledge** gained from research and innovative demonstration projects that cut across disciplines and agency boundaries through publications, clearinghouses, meeting forums and networking, such as the Learning Community at NIMH and MCH, the OSAP Drug Prevention Clearinghouse, and the forthcoming ADAMHA sponsored conference for state mental health and substance abuse administrators on models of adolescent treatment to be held in October, 1989.

PROGRAMS PROMOTING INTEGRATED SERVICES FOR ADOLESCENTS

OFFICE FOR SUBSTANCE ABUSE PREVENTION, ADAMHA

The Office for Substance Abuse Prevention (OSAP) originally established in 1986 within the office of the Administration of the Alcohol, Drug Abuse, and Mental Health Administration(ADAMHA). The Anti-Drug Abuse Act of 1988 designated OSAP as an Institute---equivalent organization---within ADAMHA. OSAP's primary purpose is to prevent alcohol and drug abuse problems, however, some of its activities also focus on early intervention and treatment. It has a strong emphasis on high-risk youth. OSAP describes its mission as follows: to review government policy related to alcohol and other drug abuse, operate a clearinghouse, operate a grant program, support the development of model programs, conduct prevention workshops, coordinate research

findings and develop prevention materials. The President's budget proposal for FY '90 is $107 million, more than a three-fold increase over the $34 million in FY '88.

In its demonstration grants program, OSAP develops prevention programs targeting high-risk youth. The legislation defines high-risk very broadly, thus permitting a much more comprehensive and integrated approach to programing. High-risk youth include individuals under 21 who have started to use alcohol and other drugs, who are the children of substance abusers, and/or are victims of sexual or physical abuse. The definition also includes high school drop outs, pregnant teenagers, the economically disadvantaged, those who have committed a violent or delinquent act, and those who have experienced mental health problems, or attempted suicide, or are disabled by injuries.

History

The 1986 Drug Abuse Act was the first legislative push for a nationwide drug prevention strategy. It authorized $52 million in FY '87 for programs with uncertainty about whether the funds were to be spent for one or two years. The office received no new funding in 1987 and many assumed that OSAP would not continue. But in 1988 Congress, responding to public outcry over drug violence and feeling the pressure to respond because of the upcoming Presidential election, passed the 1988 Anti-Drug Abuse Act which provided major funding increases in most areas of drug prevention and drug control. The new law gave renewed funds and increased authority to OSAP and established it as an independent Institute within ADAMHA, similar to the other three Institutes, NIMH, NIAAA, and NIDA.

Current Action

The 1988 infusion of funds enabled the OSAP activities to expand. OSAP's programs differ considerably from previous adolescent drug prevention programs because of their emphasis on comprehensive programs rather than strictly categorical ones. The grants fund a wide range of services to adolescents such as job training, dropout prevention, pregnancy prevention which are linked to substance abuse prevention and treatment.

In February 1989, OSAP issued a request for grant applications from service organizations and states that could provide programs for youth in three new areas and one previous one. These programs are:

1. Demonstration Grants for the Prevention, Treatment and Rehabilitation of Drug and Alcohol Abuse Among High-Risk Youth

This grant program was originally established in 1986 and is continuing. The OSAP goals for the program are to support demonstration programs in communities that will develop and evaluate innovative approaches at the client and/or service systems levels targeted toward: decreasing the incidence and prevalence of drug and alcohol use among high-risk youth; involving a youth's family and community to discourage substance abuse; coordinating and integrating the human service systems and other social services dealing with high-risk youth; increasing the availability and accessibility of prevention, treatment and rehabilitation services for these populations and reducing the severity of impairment and promoting the rehabilitation of youths already using alcohol and other drugs. An estimated $7 million will be available in FY '89 to support approximately 35 new grants under this announcement. Of the funds awarded to each grantee 15-20% must go toward evaluation of the program.

2. Alcohol and Drug Abuse Demonstration Grants in Community Youth Activity Program

The purpose of this grant program to states is to establish and evaluate innovative alcohol and other drug abuse prevention service programs for youth. This grant program is intended to enable states to identify communities where the risk of alcohol and other drug abuse is high. The program announcement encourages **integration** with other youth projects such as drug prevention programs, treatment and rehabilitation programs, juvenile justice programs, education, housing, employment, social welfare, and physical and mental health programs.

OSAP will fund this project through a single agency designated by the Governor such as a local education agency, a law enforcement agency, a community-based organization, community action organization, a local or state recreational department or business organization, and in consultation with local state health departments and with community health or mental health centers. The legislation which established this grant program requires an evaluation of activities and projects conducted through the grants. An estimated $10.6 million each year will be available to support grant awards to states under this program.

3. Model Projects for Pregnant and Postpartum Women and their Infants

Because of the danger that mothers who abuse alcohol, cigarettes and illegal drugs bring to their unborn children, OSAP is joining with the Office of Maternal and Child Health in providing funds for a collaborative, inter-agency grant program to support demonstration projects that address this problem. An estimated $4.5 million in FY '89 will be available to support approximately 20-25 grants in the first year.

The goals of the programs are to: increase the availability of prevention, early intervention, and treatment services for these populations, decrease the incidence and prevalence of drug and alcohol use among pregnant and postpartum women and improve the birth outcomes of women who used alcohol and other drugs during pregnancy.

The programs may be targeted on abusers of non-prescribed drugs, including alcohol and tobacco. The programs will also attempt to address all aspects of a patients needs including: biological/physical (e.g. detoxification, dietary, obstetrical); psychological (e.g. support, treatment for anxiety, depression, low self-esteem); instrumental (e.g. child care, transportation, housing); and informational and educational.

4. National Training System. OSAP will provide funds for training substance abuse counselors and other related health professionals in fiscal 1989. The data from this initial program will be used to established training programs for counselors throughout the country in 1990. During the 1989 fiscal year, OSAP will spend $3.5 million through two contracts to launch its national training system. The initiative responds to the critical shortage of substance abuse workers.

CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP), NATIONAL INSTITUTE OF MENTAL HEALTH, ADAMHA

(Source: Cross et al. 1989; Knitzer, 1982 and 1988; Stroul and Friedman, 1986 and 1988; Intergovernmental Health Policy Project, 1989)

The **Child and Adolescent Service System Program** (CASSP) is a premier example of how a small amount of federal dollars can be used to catalyze systems-wide change at state and community levels. In 1984, the Congress appropriated a small amount of money, $1.5 million,

for a new federal program for seriously emotionally disturbed children and adolescents, to be called the Child and Adolescent System Service Program. These monies, in the form of grants, were to be used by states to "create or strengthen the focus on children and adolescents within the states mental health program, to provide leadership in developing systems of services for the target population, and, ultimately, to implement on a demonstration basis systems of care in selected communities" (Knitzer, 1987). This allocation for CASSP was included as part of the budget for the Community Support Program, which was federal seed money to help communities set up systems of care for chronically mentally ill adults.

The program was much welcomed by the states and has grown substantially in five years at a period of general budgetary cutbacks in health services for children. Currently 42 states have received CASSP grants, and the program received $7.4 million in appropriations for fiscal year 1988-89.

The target population for CASSP funded activities is quite broad. It includes children up to the age of 18, and at state discretion 21, who meet the following criteria: who are not functioning in the family, school and community; who require multiple agency services; whose difficulties have been, or are expected to be present for at least one year, and who are diagnosed with a mental, emotional psychiatric disorder (using the classification schema set out in DSM III R). While it is not possible to track the extent to which CASSP funded activities focus specifically on adolescents, clearly in many states and communities, seriously emotionally disturbed teenagers, especially those not living at home, are a major concern.

The CASSP program represents the first federal effort to confront the fragmentation within the children's mental health system. Importantly, it also requires the states to develop a cross agency approach and tackle the issues of coordination and continuity of care between the mental health and other service systems for children such as juvenile justice, education and child welfare, and primary health care. Although CASSP proponents and written materials seldom refer to the concept of service integration, in fact the philosophy and principles of the systems of care framework come very close to the concept of integration as it is defined and used in this report.

Systems of Care Framework. CASSP monies funded a technical assistance center at Georgetown University's Child Development Center to provide assistance to states as they develop and implement their plans for using CASSP funds. CASSP has also funded two research and training centers cooperatively with the Department of Education's National Institute on Disability and Rehabilitation Research. These two university-based centers are in Portland, Oregon and Tampa, Florida. Center staff, in a number of published volumes, have carefully and comprehensively laid out the basic framework, principles and components of the systems of care needed for emotionally disturbed children (See Stroul and Friedman, 1986 & 1988). The philosophy and detailed ideas underlying the CASSP program have built upon several years of study and debate in the children mental health community, most notably Jane Knitzer's landmark study for the Children's Defense Fund (1982), the 1969 report of the Joint Commission on Children's Mental Health, and the federal **Most in Need** program which was instituted in certain Native American communities (Stroul, 1983).

The Systems of Care framework is illustrated graphically in Tables 1 and 2, pages 21 & 22. Three core values are central to the framework: that the system must be child-centered, family-focused and community-based. Ten guiding principles have been developed and include the following which are especially pertinent to the issue of integration.

---An emphasis on a coordinated, continuum of services to meet the individualized needs of every child and family.

---Services given within the least restrictive environment that is clinically appropriate.

---Development of strong linkages between all the various systems serving children in the planning, developing and implementation of services.

---The families and surrogate families should be full participants in all aspects of planning and delivery of services.

---Services must not discriminate on the basis of race or ethnic identity and must be delivered in a culturally appropriate and sensitive manner.

A strong, innovative focus of CASSP has been its activities designed to support and strengthen parent involvement at all levels. CASSP requires its grantees to involve parents at the individual level in the development of treatment plans for their child or teenager, at the community level in the assessment of communities' needs for improved services, and at the state level in the design of improved policies. Beginning in 1986, CASSP has sponsored a series of workshops and conferences around the country designed to sponsor parent-professional collaboration, called **Families as Allies** (Friesen et al. 1988).

It is difficult to summarize briefly the experience of CASSP to date. Within the broad parameters of the program, in their proposals each state is free to set their own goals based on an assessment of their own problems, and which particular group within the target population was in most need. And indeed each state has used the monies very differently. Generally the monies have been used to fund the kinds of policy and program tools and strategies discussed above, especially the development of various interagency administrative structures to establish a central focus for, and coordinate, children's services; the development of collaborative financing and coordinated budget requests, and interagency innovative training programs.

As an example, the **Alaska Youth Initiative** of the Department of Mental Health has used CASSP monies to mount a collaborative project with the Departments of Education and Health and Human Services to put an end to their joint practice of placing difficult children in institutions out of state (34 children were placed out of state in 1986). By pooling and redirecting the funds that previously went to pay for the placements, the Initiative has been able to let the "dollars follow the needs of child and family," that is, they have been spent instead on development of individualized services so that the child could remain in his or her natural community.

In its first year of operation 18 children who had been previously placed out of state were accepted into the program and another 16 had been diverted from going out of state. In addition, the youth spent 600% more time either with their families or in family-like settings and their placements were more stable.

In **Ohio**, through its State and Local Clusters on Multi-Problem Children, and in **Georgia,** through its Troubled Children Committees, CASSP funds have been used to require communities to develop interagency treatment plans for the most difficult to serve children at the local level. Only when all local resources are exhausted can the local community apply to state level agencies for assistance.

Ventura County, CA, Children's Mental Health Demonstration Project has come close to implementing the systems of care model in all its aspects and the results of the project have been highly positive in terms of outcomes for children and families and cost effectiveness for the state. Although using the systems of care framework, the Ventura project was funded not by CASSP but by a demonstration of the California State Legislature. This funding was sufficiently large to enable the county to plug the gaps in the present system and create some new services. The Ventura model is being replicated, with state monies, in three additional counties in California.

CASSP's Systems of Care model has laid out a clear set of very ambitious goals. Progress towards these goals is necessarily piece meal and arduous. The states and communities still have a long way to go and are severely hampered by the shortages of funding for children's health services. The philosophy and principles of CASSP are now broadly accepted by the states. The challenge ahead is to work to implement the framework and translate it at the service delivery level.

STATE MATERNAL AND CHILD HEALTH ADOLESCENT ACTIVITIES

In most states, Title V, Maternal and Child Health Block Grant monies are used to provide some support for health services that specifically focus on adolescents. In about twenty states these efforts have been stimulated and nurtured by a new category of state official, adolescent health coordinators whose responsibilities often include promoting the development of community-based, comprehensive programs for youth. In a few states additional grants have been given, under the Special Projects of Regional and National Significance (SPRANS) Block Grant set-aside, which have funded projects focused on the training of adolescent health care professionals, research in relation to high-risk behaviors and demonstrations for improved, integrated services for youth. Two examples of these state adolescent health activities are provided below.

COLORADO

Since 1980, Colorado has had a strong commitment to improving the status of adolescent health and has initiated a series of activities across the state. Colorado was among the first three states to appoint a director of adolescent health, who, from within the Department of Maternal and Child Health has led and coordinated many of the activities. The focus on adolescent health has however had strong support from other state agencies and in the private sector. From the start, these activities have reflected an awareness of the multiple issues involved in promoting adolescent health. Currently there are seven special statewide task forces and groups working on youth health related issues which have come together to form a State Initiatives Group (SIG) to conduct some collaborative projects.

Two multi-year demonstration projects, funded by the federal MCH SPRANS grants will be briefly outlined, the **Colorado Adolescent Project (CAP)** and the **Partners in Action for Teen Health** (PATH). The broad purpose of both of these projects has been to use state action to stimulate local awareness and action.

- **Colorado Adolescent Health Project** 1983-87. This demonstration project was an outgrowth of the work of an ad hoc adolescent health task force composed of about thirty professionals from different disciplines and agencies. After two years work they presented a comprehensive report on the status of adolescent health in Colorado. The report compiled trends in adolescent health indicators and discussed the nine major problem areas of teenagers in the state. These included mental health, teen pregnancy, substance abuse, deaths and injuries, violence, sexually transmitted diseases, smoking, nutrition and fitness. This report was updated and reissued in a much more comprehensive version in 1986 (Davis, et al.1986).

  The report led to the grant's funding demonstration projects in two urban and one rural community designed to implement a community-based model of teen health care by combining the efforts of schools, health care providers and other community members, especially parents. As a result, existing projects were linked and coordinated, for example, nurses based in community health clinics would regularly visit several middle and high schools providing case finding, referrals, health education, counseling and so forth. The project was deemed highly successful in greatly increasing teens use of reproductive and

other health services and improving their degree of compliance with suggested health regimens. An implementation manual was developed to aid other communities in replicating this coordinated model of services.

- **Partners in Teen Health (PATH)** 1987-90. The second SPRANS project had a somewhat different focus although the same basic objective to improve adolescent health. Many Colorado communities had become aware of their teenagers' health problems and wanted to do something about them. The problem was that there was no systematic approach for assisting communities in their efforts. PATH was intended to develop and test a process that communities could use that would involve all segments of the community and result in a collaborative action plan for prevention and remediation of adolescent health problems.

  The steps in this process, which is currently being tested in four communities, includes: a local needs assessment; a process for involving the nine major sectors of the community---the "partners in health"---identified in the 1986 report; a system for prioritizing the identified community concerns; and a mechanism for developing a community action plan. Parents are considered one of the nine major partners in promotion of adolescent health and parent representatives have been involved in the local planning efforts.

  In addition, the PATH project is committed to working with state agencies to develop a consistent system for ongoing collection and analysis of county-specific adolescent health data. And finally, the project will develop plans for replicating and disseminating the community development process model in other areas of the state and the nation.

- **Denver School-Based Clinics.** In 1987 the University of Colorado Health Sciences Center, in collaboration with many other agencies and groups, received a grant from the Robert Wood Johnson Foundation to support three school-based clinics. State Maternal and Child Health monies have supplemented this grant.

OKLAHOMA

Largely due to the strong commitment to the needs of adolescents of Oklahoma's Maternal and Child Health Director, the state was the first to appoint a full-time coordinator for adolescent health. Like Colorado, many of the state-directed, adolescent health activities in Oklahoma are led by the director of the adolescent health division. Unlike Colorado however, Oklahoma has not received SPRANS demonstration grants but has funded these activities largely through federal block grants and state monies, supplemented with private sector support.

In Oklahoma, the Maternal and Child Health Service now operates **14 adolescent health care clinics** located in county health departments in rural communities. These were set up in 1982 as part of the R.W. Johnson Foundation Consolidated Services High-Risk Project (see p. 15). Foundation funds to the Adolescent Medicine department of the University of Oklahoma, paid for the in-service training to health care providers and community awareness activities. State monies provided the salaries, equipment and supplies. These clinics are staffed by a multi-disciplinary team of health professionals who have received specialized training in adolescent health. The team includes nutritionists, social workers, psychologists, nurse practitioners, physicians, and public health nurses. The services they provide include mental health and substance abuse counselling. Some clinics are open after school hours. Teenagers from every income level are served, for certain services fees are charged on a sliding scale. By state law, parental permission is required thus, parents accompany the teenager to the first appointment. (If confidential family planning

services are needed the teens are referred to another clinic.) The staff provide health promotion activities, identification of high-risk behavior and early intervention, in part through the use of health screening questionnaires administered to the teen patients. Although the Foundation grants have ended, the state continues to fund the clinics at an adequate level.

One of the major structures involved in promoting the state wide focus on adolescent health is the **Oklahoma Adolescent Health Care Task Force** which was established in 1986 initially with a small federal grant from the Youth 2000 program. The Task Force has representation from several public and private agencies including education, mental health and job counselling and two universities. The Task Force approaches adolescent health as a multi-issue concern and stresses the interrelatedness of all aspects of adolescent health. Its major focus is to identify adolescent health needs, the resources available to meet those needs and recommend and promote approaches to improving the delivery and coordination of adolescent health services. In 1988, it began a series of five regional meetings around the state, attended by over 800 people to date. A major conference is planned for the fall of 1989 to focus on building collaborative community coalitions, titled "Local Communities Can Make it Happen."

Another major project is the use of the **Rhode Island Wellness Checklist** with high school populations. Upon request of the school, maternal and child health staff administer this brief, written questionnaire to students to determine the types of problems adolescents are having. The results help the school personnel decide what kinds of health education programs are needed. Also the health care professional meets with each student to review any concerns and, if necessary, refer them for services. When mental health and family counselling seems indicated the school counselors are alerted. This checklist has been administered to over 3,000 students.

Additional state activities include one day mini-conferences for junior and senior high school students focussing on various health prevention themes; a special project to encourage the use of seat belts among high school students; and a school-based primary prevention education project for preadolescents and their parents called **Dare To Be You.** This program encourages strong family support and communication, decisionmaking skills and self-responsibility and self-esteem. Volunteer leaders and youth service workers have been trained to conduct this program in communities throughout the state, reaching thousands of children and their parents.

ROBERT WOOD JOHNSON FOUNDATION'S ADOLESCENT HEALTH ACTIVITIES.

(Source: Lear, Foster and Baratz, 1989; R.W. Johnson Foundation, 1986 and 1989; ACCESS, 1988)

Since 1981, the Robert Wood Johnson Foundation has made a major financial commitment to improving the health of adolescents through launching a series of four multi-site, multi-year demonstration grant programs, described briefly below, targeted on disadvantaged youth . Themes cutting across all these programs are the interrelationship of the physical, emotional and behavioral problems of adolescents and the need to consolidate and integrate services for them. Based in part on the experience of these grant programs, currently the Foundation is seriously examining the whole issue of how health services for youth are organized and whether the time is ripe to make some fundamental changes in the present system. The Foundation's primary concern is to find ways of making services more responsive to the actual health needs both of individuals and of the public health of the population at a whole.

- **Program to Consolidate Health Services for High-Risk Young People** 1982-86. For five years this R.W. Johnson program provided grants to 21 teaching hospitals working with 54 community co-sponsors to conduct projects designed to provide community-based health services to young people at-risk for serious behavior and medical

problems. The projects pursued four specific objectives: to increase health services to high-risk youth; to train health professionals in their care; to consolidate existing health services into comprehensive care centers, and to secure long-term support for these adolescent health services.

The projects had considerable success in providing health services to the communities' youth population, but it was not clear if these teens were previously medically unserved because the patients' previous medical care was undocumented. The projects provided a great deal of training through clinical specialty fellowships, residents training, and in-service training for clinic staff and community health care professionals. Although 17 out of 20 of the projects were successful in obtaining stable sources of long-term funding, the projects did not succeed in truly integrating existing programs, rather they added new, more comprehensive components to existing programs. Overall the projects clearly greatly increased the level of awareness and knowledge of adolescent health needs and problems in the surrounding communities.

- **School-Based Adolescent Health Care Program** 1987-93. In the summer of 1987, the R.W. Johnson Foundation awarded 18 six-year grants to a variety of sponsoring organizations to establish school-based clinics providing comprehensive care. The $12 million program was an outgrowth of the Foundation's five year program's success in locating health services in elementary schools, and their experience with the High Risk Consolidation project which suggested that services needed to be made more accessible to underserved adolescents. The school-based clinics, located in cities, offer a variety of primary care services and, through linkage with other health care institutions, provide some substance abuse and mental health counselling. Experience to date shows that up to 50% of the visits are for acute illness or physical examinations, and only 10% for reproductive health. Integrating mental health and substance abuse services into these clinics, especially services that are sensitive to minorities, has been a difficult challenge. Special grants have been awarded to develop model programs for this purpose. The program has laid a strong emphasis on the need to plan the clinics in consultation with the community's local leaders including parents and youth themselves and set up a formal community advisory committee to provide on-going support and advice and help seek additional matching funding from public and private sources. The projects are being evaluated by an independent contractor.

- **Mental Health Services Program for Youth** 1988-93. In keeping with the Foundation's growing interest in mental health care for adolescents, it has initiated a five-year, $20.4 million program designed to improve the organization and integration of services for seriously emotionally disturbed children and adolescents. Key elements of this program are state and local agency partnerships, strong community interagency agreements, case management services, and a continuum of mental health and support services. The philosophy of the program is, in effect, to implement the CASSP systems of care model outlined above. Planning grants will be awarded to 12 organizations, with up to eight of these projects awarded four-year implementation grants.

- **Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol** 1989-96. Early in 1989, the Foundation announced a new $26.4 million program to support intensive, community-wide initiatives to reduce the demand for illegal drugs and alcohol. The program again lays strong emphasis on integrating existing services, and ensuring a continuum of services from prevention, through early intervention and treatment. The program is intended for medium size communities that are experiencing serious problems with substance abuse. Each applicant community must establish a citizen's task force on drug and alcohol abuse to provide oversight, guidance and support. Members of the task force should include representatives of all the groups whose involvement and commitment are needed for the initiative to succeed, including parents.

Similarly a consortium must be formed of all the institutions whose participation is required to implement the project. Although the projects may address any age group, the prevention efforts must be targeted especially at children, adolescents and young adults. In the first phase of the program up to 12 one to two-year planning grants will be awarded, with up to eight awarded five-year implementation grants.

PARENTS AS RESOURCES

One of the major innovative themes of these service integration projects described above is that parent representatives are considered to be a valuable program resource to provide general program advice and support and to be involved directly in prevention, education, treatment and support services provided to their adolescents. This is a major change from the traditional model of categorical service delivery to adolescents which generally excluded parents.

This new emphasis on parent involvement reflects both the change to a systems philosophy of health care and a growing responsiveness to the emerging parent consumer movements. This movement has been the strongest among parents of "special needs" children---children with chronic illness or handicap. But it is growing in other areas as well. Parents are not yet organized on a national basis to advocate and promote more integrated primary health care services for children and adolescents although locally they have, as we have just noted, been very involved especially in the school-based clinic movement. And the National Parent Teacher Association in recent years has become somewhat more interested in adolescent health issues. However, parents have been much more active in the fields of substance abuse and mental health.

In the last ten years there has been a dramatic rise in the number of local and state parent groups, mostly headed by women, organizing to support each other and pressure governments to do more about the high levels of teenage drinking, illegal drug use and drinking and driving. The groups have organized prevention efforts, such as closing paraphernalia shops in their community and changing drunk driving laws. Although they have been successful in educating the public, their groups have received little funding. In the area of treatment these parent groups contend that parents **must** be involved in order for treatment to be effective. While considerable emphasis was placed on grassroots efforts to stop drug use under First Lady Nancy Reagan's "Say No to Drugs" campaign, there was no federal money given to parent groups (although some private funds were raised).

Another area of adolescent health where parents groups are organizing is in the treatment of child mental illness. Parent groups, like NAMI CAN and the Federation for Families for Children's Mental Health, have organized to support one another, and lobby for better services for children and their family members, and push for more research in the field of mental health. Five statewide parent networks focusing on parent-professional collaboration have received financial support and encouragement from the federal CASSP program.

Families in Action. Families in Action, a parent organization, operates a national information center on drug-abuse prevention. Its purpose is to educate society about the dangers of drug abuse by disseminating accurate and timely information. The center houses a library, publishes a quarterly newsletter, and provides answers to written and telephone requests. It also provides referrals for treatment.

Contact: Sue Rusche, President, National Drug Information Center of Families in Action, 2296 Henderson Mill Road, Suite 204, Atlanta, GA 30345, (404) 934-6364.

National Federation of Parents for Drug Free Youth (NFP) is a national organization of parents and other Americans who are committed to preventing alcohol and illegal drug use by young people. The primary purpose of the NFP is to serve as a catalyst for community-based facilitation programs that will be effective in the prevention of alcohol and other drug use by youth. Its Washington, DC office was closed for lack of funding.

Contact: Ruby Smith, 1423 N. Jefferson, Springfield, MO 55802-1988. (417) 836-3709.

Mothers Against Drunk Driving (MADD)
MADD was started in 1980 by Candy Litner of California. The group advocates for victims and attempts to educate the public about drunk driving. MADD lobbies at state and federal level for tougher penalties, to make laws consistent with their belief that drunk driving should be unacceptable. It also works on laws and programs to discourage alcohol use among teenagers.

Contact: Mickey Sadoff, President:, MADD, 699 Airport Freeway, Suite 310, First, Texas 76053. (817) 268-MADD.

The Federation for Families for Children's Mental Health,
The Federation is a parent organization whose purpose is four fold: to ensure the rights to full citizenship and support and access to community-based services for all children and youth with emotional behavioral and mental disorders; to address the unique needs of children from birth to adulthood; to educate and engage in advocacy regarding research prevention, early intervention, family support education and transition services needed by children and youth; to provide leadership in the field of children's mental health and development of necessary human and financial resources to meet these goals.

Contact: Barbara Huff, President, Federation for Families for Children's Mental Health, c/o Keys for Networking, 4125 S.W. Gage, Center Drive, Suite 201, Topeka, KS 66604.

NAMI CAN
NAMI CAN (the National Alliance for the Mentally Ill, Children and Adolescent Network) was formed to focus and coordinate efforts to help mentally ill children and their families. NAMI CAN is a grassroots, self-help support and advocacy organization of parents and friends of mentally ill children affiliated with its parent organization NAMI. Its members sponsor support groups for families, public education and advocating for improved public understanding, improved services and more research on mental illness in children and adolescents.

Contact: Carol Howe, National Alliance for the Mentally Ill, 2101 Wilson Boulevard, Suite 302, Arlington, VA 22201. (202) 933-3744.

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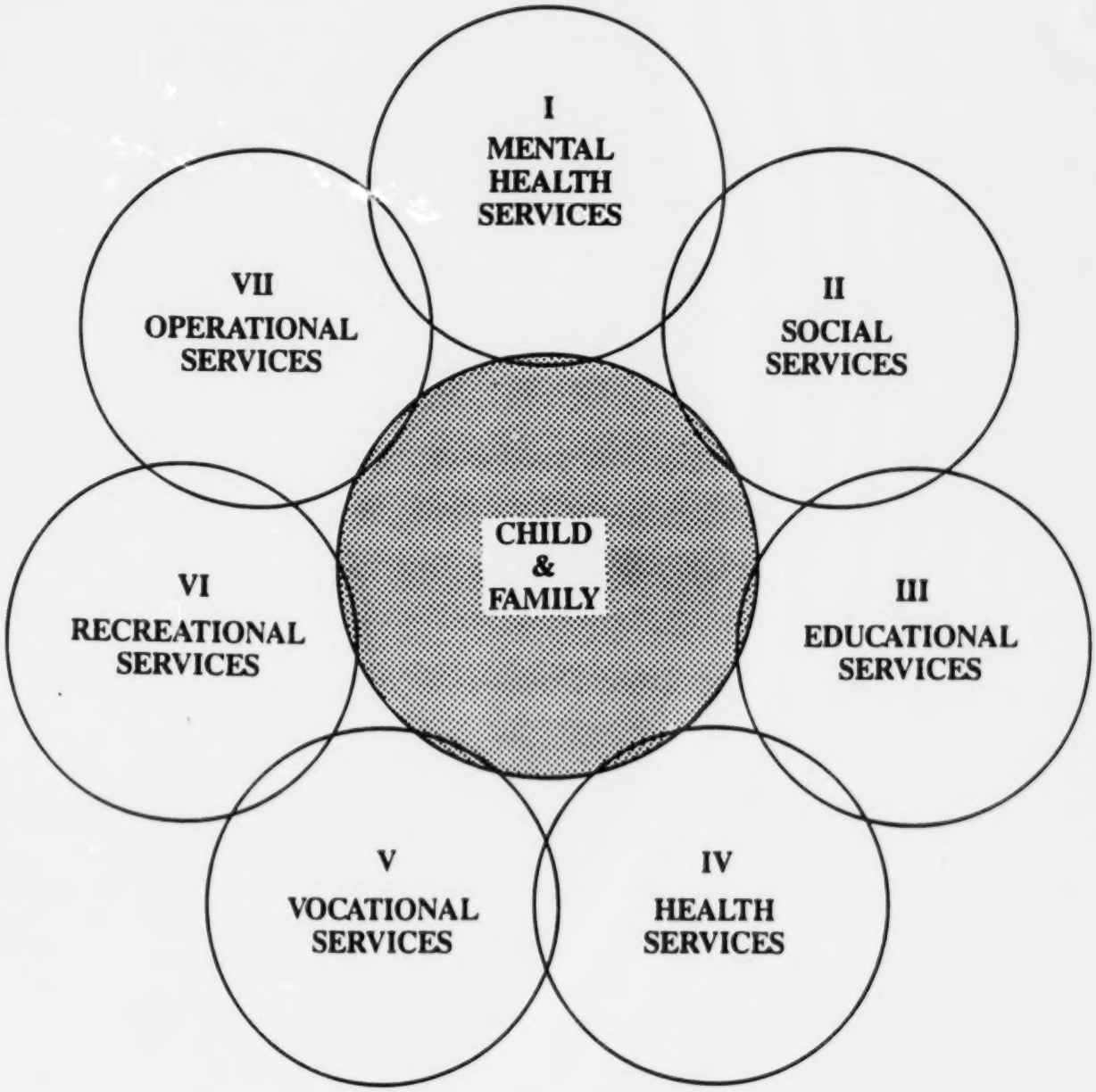
SYSTEM OF CARE FRAMEWORK



From: Stroul, B.A. & Friedman, R.M. A System of Care for Severely Emotionally Disturbed Children and Youth. July 1986. Available from, CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Rd NW, Washington DC 20007

TABLE 9

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

Prevention
Early Identification & Intervention
Assessment
Outpatient Treatment
Home-Based Services
Day Treatment
Emergency Services
Therapeutic Foster Care
Therapeutic Group Care
Therapeutic Camp Services
Independent Living Services
Residential Treatment Services
Crisis Residential Services
Inpatient Hospitalization

2. SOCIAL SERVICES

Protective Services
Financial Assistance
Home Aid Services
Respite Care
Shelter Services
Foster Care
Adoption

3. EDUCATIONAL SERVICES

Assessment & Planning
Resource Rooms
Self-Contained Special Education
Special Schools
Home-Bound Instruction
Residential Schools
Alternative Programs

4. HEALTH SERVICES

Health Education & Prevention
Screening & Assessment
Primary Care
Acute Care
Long-Term Care

5. VOCATIONAL SERVICES

Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement & Retention Services
Sheltered Employment

6. RECREATIONAL SERVICES

Relationships with Significant Others
After School Programs
Summer Camps
Special Recreational Projects

7. OPERATIONAL SERVICES

Case Management
Self-Help & Support Groups
Advocacy
Transportation
Legal Services
Volunteer Programs

From: Stroul, B.A. & Friedman, R.M. 1986, p. 105.